U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7500
(202) 693-7365 (FAX)

Issue date: 31May2002

In the Matter of

MR. CURTIS M. HORNER
Claimant

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case No.: 2001 BLA 761

APPEARANCES: Mr. Ron Carson, Personal Representative
For the Claimant

Mr. Douglas A. Smoot, Attorney
For the Employer

BEFORE: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER -
DENIAL OF MODIFICATION REQUEST
DENIAL OF REQUEST FOR WITHDRAWAL OF CLAIM

This matter involves a claim filed by Mr. Curtis M. Horner for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

I conducted a formal hearing in Abingdon, Virginia, on October 2, 2001, attended by Mr. Carson, and Mr. Smoot. Mr. Horner was not able to attend the hearing and, as to be discussed, he requested through Mr. Carson the withdrawal of his claim. My decision in this case is based on all

the documents admitted into evidence (DX 1 to DX 85 and EX 1 to EX 6).[1]

Procedural Background

On March 28, 1996, Mr. Horner filed his claim for black lung disability benefits under the Act (DX 1). After an pulmonary examination, a representative for the District Director denied the claim in July 1996 because the evidence failed to establish that Mr. Horner was totally disabled due to pneumoconiosis (DX 16). In response, on August 30, 1996, Mr. Carson, on Mr. Horner's behalf, requested an administrative law judge hearing (DX 17). However, the District Director conducted an informal conference in December 1996 and then issued a Proposed Decision and Order on January 15, 1997 denying Mr. Horner's disability claim (DX 34). The majority of the chest x-ray readings were negative for pneumoconiosis, but at least one examining physician believed Mr. Horner had pneumoconiosis. However, the objective medical evidence did not establish a totally disabling pulmonary condition. Even the physician who found the presence of pneumoconiosis opined Mr. Horner was not sufficiently disabled to preclude his return to coal mine employment. On January 28, 1997, Mr. Carson once again requested an administrative law judge hearing (DX 37). This time, the District Director forwarded the case to the Office of Administrative Law Judges ("OALJ") on February 25, 1997 (DX 41).

Pursuant to a Notice of Hearing, dated May 7, 1997, Administrative Law Judge Stuart A. Levin conducted a hearing in Abingdon, Virginia, on July 8, 1997, with Mr. Horner, Mr. Carson, and Mr. Smoot (DX 45 and DX 48). On November 4, 1997, after noting the evidence concerning the presence of pneumoconiosis was mixed, Judge Levin denied Mr. Horner's claim because he was unable to establish one of the critical elements of entitlement - total respiratory impairment (DX 50). Judge Levin determined that neither the objective medical tests nor the physician opinions indicated that he was unable from a pulmonary perspective to return to coal mining. On November 13, 1997, Mr. Carson appealed the denial of Mr. Horner's claim (DX 51).

On December 16, 1998, the Benefits Review Board ("BRB" or "Board") affirmed Judge Levin's findings and denial of benefits (DX 56). The Board observed that the pulmonary function tests, arterial blood gas studies and physician medical opinions did not support a finding of total disability.

On September 21, 1999, Mr. Carson submitted a request for modification support by a pulmonary function test and a medical opinion that Mr. Horner was totally disabled (DX 57 and DX 69). On April 10, 2000, the District Director denied Mr. Horner's modification request due to his failure to show a change in conditions or mistake of fact (DX 72). In reply, Mr. Carson sent in

[1]The following notations appear in this decision to identify exhibits: DX - Director exhibit; EX - Employer exhibit, ALJ - Administrative Law Judge exhibit, and TR - Transcript of the hearing. In light of Mr. Horner's withdrawal request, Mr. Carson did not submit any documents on Mr. Horner's behalf. Rather, in the event of an adverse decision on the withdrawal request, Mr. Carson requested a decision on the record (TR, pages 9 to 12).

another chest x-ray (DX 75). On March 27, 2001, the District Director once again denied modification due to the absence of a change in conditions or mistake of fact (DX 80). Mr. Carson appealed on April 19, 2001 (DX 82). The District Director forwarded the case to OALJ on May 1, 2001 (DX 84). Pursuant to a Notice of Hearing, dated June 5, 2001 (ALJ I), I conducted a hearing in Abingdon, Virginia on October 23, 2001.

ISSUES

1. Withdrawal of Claim

2. Whether Administrative Law Judge Stuart Levin's denial of Mr. Horner' claim on November 4, 1997, as affirmed by the Benefits Review Board, should be reconsidered in light of Mr. Horner's September 21, 1999 request for modification

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the hearing, the parties stipulated that Westmoreland Coal Company is the Responsible Operator and Mr. Horner has more than ten years of coal mine employment (TR, pages 14 and 15). Additionally, at the July 8, 1997 hearing before Judge Levin the same parties stipulated that Mr. Horner had 26 years of coal mine employment (DX 48, page 10).

Issue No. 1 - Withdrawal of Claim

At the hearing before me, Mr. Horner requested, through Mr. Carson, that he be permitted to withdraw his claim. According to Mr. Carson, withdrawal is in Mr. Horner's best interest because he has realized his case is not yet fully developed and he could re-file later when a disability develops (TR, pages 5, 7, and 10). Counsel for the Employer, Mr. Smoot, objected to the withdrawal of the claim on the basis that the Benefit Review Board had already issued a decision on the underlying claim that generated the present modification request. While not objecting to the withdrawal of the modification request, Mr. Smoot believed withdrawal of the claim itself was inappropriate because that process would permit a claimant to avoid adverse litigation by simply withdrawing his claim after the decision is issued. Such an action would mean there was no finality to adjudicated decisions (TR, page 6).

Under the terms of 20 C.F.R. § 725.306 (a) (1),[2] a claimant, or a person on his behalf, may withdraw a previously filed claim based on a written request[3] to the appropriate adjudication officer with reasons that reflect such a withdrawal is in the claimant's best interest. According to 20 C.F.R. C.F.R. §§ 725.306 (a) (2) and (3), approval of the withdrawal is conditioned upon a) a finding that the action is in the claimant's best interest; and, b) the reimbursement of any prior benefits that the claimant has received under 20 C.F.R. § 725.522. The effect of an approved withdrawal is that the claim will be considered not to have been filed. 20 C.F.R. § 725.306 (b).

Although not specifically stated within the four corners of 20 C.F.R. § 725.306, I believe the withdrawal authorization contemplates such an action before a final adjudication of a claim for several reasons. First, the regulation references an adjudication officer which is defined at 20 C.F.R. § 725.50 as either a district director or administrative law judge. Not only does this reference imply the action is appropriate while an adjudication is pending, the section fails to mention the Benefits Review Board ("BRB" or "Board"), the administrative appellate review body in black lung disability claims. At the BRB level, the regulation only authorizes the Board to consider dismissal of an appeal based on a party's motion *prior* to issuance of a decision. 20 C.F.R. § 802.401.[4] Thus, it appears that a claimant would be unable to withdraw his claim once it's before the BRB for consideration. Second, based on the best interest criteria, it is difficult to imagine how the withdrawal of a claim, post adjudication, sufficiently alters a claimant's position to the extent the withdrawal is in his or her best interest.[5] Third, and most significant, while the requirement relating to the reimbursement of

---

[2]Since Mr. Horner filed his modification request, DOL has issued new regulations relating to black lung disability claims. Many of the amended provisions of 20 C.F.R. § 725 are applicable now, while other sections of Part 725 are applicable only to claims filed after the effective date of the new regulations. *See* 20 C.F.R. § 725.2 (c). For example, the provisions in the new regulations concerning the withdrawal of claims and the finality of decisions, and the ability to request a modification, 20 C.F.R. § 725.306, 20 C.F.R. § 725.479, 20 C.F.R. § 725.480 apply to Mr. Horner's case; whereas, the former provision relating to the modification process, 20 C.F.R. § 725.310 (pre-2000), must be utilized.

[3]The regulation requires that the request be written. However, I consider Mr. Carson's oral request on the verbatim record of the October 2, 2001 hearing a sufficient substitute.

[4]Unlike the withdrawal of a claim, a dismissal of an appeal merely renders the underlying administrative law judge's decision and order final.

[5]The limited evidence provisions of the new regulations does raise the possibility that withdrawal of a claim after an adverse decision to the claimant might benefit a claimant in a subsequent claim. Absent the withdrawal of the claim, the adverse adjudicated claim becomes part of the record for any subsequent claim. Whereas, the approved withdrawal of such an adjudicated claim would have the effect of wiping out the entire medical history and evaluations associated with the claim. In that case, only the evidence developed in association with the new claim, as limited by the new regulations, would be in the record, possibly to the claimant's benefit. In his request for the withdrawal of Mr. Horner's claim, Mr. Carson did not include such a consideration as a basis for approval. I am skeptical that the withdrawal provision contemplates such a purpose. I also note that courts interpreting the related withdrawal provisions of longshoreman disability compensation claim have imposed a proper purpose constraint in determining whether such an action should be approved. *See Matthews v. Mid-States Stevedoring Corp*, 11 BRBS 139 (1979) . Although 20 C.F.R. § 725.306 does not contain the specific words

(continued...)

previously paid benefits seems to imply a post-adjudication situation, the referenced payments involve 20 C.F.R. § 725.522, which is captioned, "Payments *prior* to final adjudication" (emphasis added). In other words, the payments addressed in 20 C.F.R. § 725.306 are the interim payments the district director may initiate pending the final resolution of a claim.

Having determined that 20 C.F.R. § 725.306 authorizes the withdrawal of a claim prior to a final adjudication, and since Mr. Horner's claim had been through several adjudications prior to my hearing, I next consider when a claim and its associated adjudication becomes final. Besides satisfying the public policy consideration of having final resolution of claims, the finality of a decision also has a regulatory effect. For example, when a district director's proposed decision and order has become final, 20 C.F.R. § 725.419 (d) states "all rights to further proceedings with respect to the claim shall be considered waived, except as provided in § 725.310," which covers modification procedures. At the district director level, the adjudication decision after the collection of evidence is considered a proposed decision and order. 20 C.F.R. § 725.418 (pre-2000). The proposed decision only becomes final if the parties do not request within 30 day a revision or an administrative law hearing. 20 C.F.R. § 725.419. In the same manner, an administrative law judge's decision and order becomes final after 30 days that it's filed with the district director unless a party requests a reconsideration or files an appeal to the BRB within the 30 day time frame. 20 C.F.R. §§ 725.479 (b) and 725.481. Finally, a decision of the Benefit Review Board becomes final after the expiration of 60 days if no request for reconsideration or appeal to a U.S. circuit court of appeals is filed during that time. 20 C.F.R. § 802.406.

At this point, in light of the regulatory provisions on the finality of decisions, and considering that by the time of my hearing Mr. Horner's claim had already been denied by Administrative Law Judge Stuart Levin and that denial had been affirmed by the Benefits Review Board, I conclude that the decision by the BRB to affirm Judge Levin's denial of Mr. Horner's claim became final on February 16, 1999 (60 days after issuance of the decision) , which had the effect of making Judge Levin's denial of benefits a final decision and order on Mr. Horner's claim. Consequently, Mr. Horner is unable to now withdraw his claim unless some regulatory device exists to breath renewed viability into his finally denied claim.

---

[5](...continued)
"proper purpose," that appear in the longshoreman claim withdrawal provision, 20 C.F.R. § 702.225 , I believe the courts' reasoning on the proper purpose provision would have equal applicability to the withdrawal of black lung disability claims.

At this point, having referenced the longshoreman claim withdrawal provision, I further observe that 20 C.F.R. § 702.225 (b) does permit the withdrawal of a claim *post* adjudication after the Office of Worker's Compensation Programs ("OWCP") determination, conditioned upon best interest, proper purpose and reimbursement of previously paid benefits. However, the Benefits Review Board has concluded that provision applies only to OWCP determinations based on informal proceedings that did not require transfer of the case to the Office of Administrative Law Judges. *Graham v. Ingalls Shipbuilding*, 9 BRBS 155, 158 n. 2 (1978).

Because Mr. Horner is before me based on his timely modification request following the BRB's decision, he may have an avenue of relief since 20 C.F.R. § 725.480, states a party "dissatisfied with a decision and order which has become final in accordance with § 725.479 may request a modification of the decision if the conditions set forth in § 725.310 are met." In turn, 20 C.F.R. § 725.310 (a) (pre-2000) provides that within one year of the denial of benefits or the date of last payment of benefits, on the grounds of a mistake in the determination of fact or a change of conditions, "the terms of an award or denial of benefits" may be reconsidered. If such a modification order is warranted, it "may terminate, continue, reinstate, increase or decrease benefits payments or award benefits," 20 C.F.R. § 725.310 (d) (pre-2000).

Unfortunately, the regulations are silent about whether, upon modification, a claimant may then withdraw his claim. Understandably, the ability of a claimant to undo both a BRB final decision and an administrative law judge final decision and order simply by withdrawing his claim during the modification process seems to run contrary to the importance of judicial finality. However, according to 20 C.F.R. § 725.310 (d) (pre-2000), if Mr. Horner successfully establishes that a modification is appropriate due to a mistake of fact or a change in condition, the adjudicated decision is no longer final and becomes subject to appropriate alteration, or modification. As a result, by establishing that modification of the final decision is warranted, Mr. Horner is able to undo the finality of the decision which I believe also enables him to withdraw the claim at that time. Importantly, it's not the modification process itself that alters the finality of Judge Levin's decision and order as affirmed by the BRB. The final decision in Mr. Horner's case becomes subject to alteration, and the claim becomes open to a withdrawal action, only if he establishes either a mistake of fact or change in conditions.[6]

Issue No. 2 - Modification

According to the BRB, under these regulatory provisions, to determine whether a claimant demonstrates a change in conditions, an administrative law judge ("ALJ") must conduct an independent assessment of all newly submitted evidence and consider this evidence in conjunction with all evidence in the official Department of Labor record to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. *Gingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), aff'd. on reconsideration, 16 B.L.R. 1-71 (1992).

The modification process has been further expanded by the United States Supreme Court and federal Courts of Appeals when they considered cases involving the mistake of fact factor listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the

[6]Arguably, if a claimant prevails on a modification request, the withdrawal of his claim may no longer be in his best interests. Because Mr. Horner ultimately was unable to establish that a modification was warranted, I did not have to address this possible outcome of permitting withdrawal of a claim upon a successful modification action.

United States Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." See also *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987).

A. Change of Conditions - Total Disability

In the prior adjudications, the central basis for denial of Mr. Horner's claim has been the absence of a totally disabling pulmonary impairment. Accordingly, to decide whether a change in conditions has occurred, I will examine the new medical evidence developed since the denial of Mr. Horner's claim in November 1997. If the preponderance of that evidence shows that Mr. Horner has become respiratorially disabled then he has established a change in conditions.

The third necessary element for entitlement of benefits is total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §718.204 (b) (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills (20 C.F.R. § 718.204 (b) (1)).

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. The U.S. Court of Appeal for the Third Circuit has held that, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.[7]

Mr. Horner has not presented evidence of cor pulmonale with right-sided congestive heart failure. Further, there is no evidence of complicated pneumoconiosis. As a result, Mr. Horner must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion developed since the BRB affirmed-denial of his prior modification request by Judge Levin in November 1997.

Pulmonary Function Tests

[7] *See Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993(3d Cir. 1995).

Exhibit	Date/ Doctor	Age/ height	FEV_1 pre[8] post[9]	FVC pre post	MVV pre post	%FEV_1/ FVC pre post	Qualified[10] pre post	Comments\
DX 61	Sep 18, 1998	58 74.0"	2.70 - - -	3.67 - - -	- - - - - -	73	No[11]	Mild restriction
DX 57 DX 69	Feb 25, 1999 Dr. Smiddy	58 74.0"	- - - 2.39	- - - 3.55	- - - - - -	- - - 67	 No	(No tracings)
DX 57	Sep 20, 1999 Dr. Craven	59 74.0"	2.68 - - -	3.89 - - -	76 - - -	69 - - -	No[12]	Mild obstruction, possible restriction (DX 59 - valid per Dr. Zaldivar)
DX 62	Oct 27, 1999 Dr. McSharry	59 73.0"	3.02 3.06	4.62 4.75	104 - - -	65 64	No[13]	Very mild obstruction
EX 3	Aug 15, 2001 Dr. Hippensteel	61 72.0"	2.27 2.40	3.74 3.79	96 - - -	61 63	No[14] No	Minimal Obstruction

None of the tests administered since the November 1997 denial of Mr. Horner's last modification request produced a result that qualified under the regulation to establish total disability. Mr. Horner is unable to establish a totally disabling pulmonary condition through the preponderance of the pulmonary function tests.

Arterial Blood Gas Studies

---

[8]Test result before administration of a bronchodilator.

[9]Test result following administration of a bronchodilator.

[10]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV_1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. §718, **and either** the FVC has to be equal or less than the value in Table B3, **or** the MVV has to be equal or less than the value in Table B5, **or** the ratio FEV_1/FVC has to be equal or less than 55%.

[11]The qualifying FEV_1 number is 2.40 for age 58 and 74.0". The associated qualifying FVC and MVV values are 3.05 and 96, respectively.

[12]The qualifying FEV_1 number is 2.39 for age 59 and 74.0". The associated qualifying FVC and MVV values are 3.03 and 96, respectively.

[13]The qualifying FEV_1 number is 2.29 for age 59 and 73.0". The associated qualifying FVC and MVV values are 2.91 and 92, respectively.

[14]The qualifying FEV_1 number is 2.20 for age 61 and 72.0". The associated qualifying FVC and MVV values are 2.80 and 88, respectively.

Exhibit	Date/ Doctor	$_pCO_2$ (rest) $_pCO_2$ (exercise)	$_pO_2$ (rest) $_pO_2$ (exercise)	Qualified[15]	Comments
DX 57 & DX 69	Feb 25, 1999 Dr. Smiddy	38	78	No[16]	
DX 62	Oct 27, 1999 Dr. McSharry	38	73	No	
EX 3	Aug 15, 2001 Dr. Hippensteel	38.5	70.4	No	Normal for age

The three blood gas studies accomplished since November 1997 also failed to produce any qualifying results under the regulations. As a result, Mr. Horner cannot demonstrate total respiratory disability with the blood gas tests.

Medical Opinion

When total disability cannot be establish based on the presence of complicated pneumoconiosis, cor pulmonale, pulmonary function tests, or arterial blood gas studies, a claimant may still establish total disability through reasoned medical opinion. According to 20 C.F.R. § 718.204 (b) (2) (iv), total disability may be found

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) (1) of this section.

And, as previously discussed, 20 C.F.R. § 718.204 (b) (1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. To evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Exertional Requirements

Based on the above principles, the first step in my analysis is to determine the exertional

[15]To qualify for Federal Black Lung disability benefits at a coal miner's given $_pCO_2$ level, the value of the coal miner's $_pO_2$ must be equal to or less than corresponding $_pO_2$ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[16]For the $_pCO_2$ of 38, the qualifying $_pO_2$ is 62.

requirements of Mr. Horner's last job in coal mining as a service utility man. Based on his work histories and previous testimony, I find Horner engaged in heavy manual labor due to the job requirement to lift and carry objects weighing up to 50 pounds (DX 3, DX 10, DX 48, page 11, EX 4, page 10 - reference by Dr. Hippensteel; and EX 5 - reference by Dr. McSharry)

Medical Evaluations[17]

Having established the physical requirements of Mr. Horner's utility man job, I next review the medical opinion in the record to determine if the preponderance of the medical opinion supports a finding of total disability. Prior to discussing the actual diagnoses of these physicians, a review of the chest x-ray interpretations presented since November 1997 helps place the physicians' diagnoses in perspective.

Chest X-Rays

Date of X-Ray	**Exhibit**	**Physician**	**Interpretation**
Feb 25, 1999	DX 57and DX 69	(Referenced by Dr. Smiddy)	Severe coal workers' pneumoconiosis (as reported by Dr. Smiddy)

[17]On July 6, 1999, Dr. Escasinar treated Mr. Horner for a possible myocardial infarction. Upon physical examination the lungs were clear with bilateral breath sounds. Dr. Escasinar diagnosed possible myocardial infarction, hypertension, COPD, and tobacco abuse with the consumption of a pack and a half of cigarettes a day. Since he did not render an opinion on total disability, I have not considered his opinion in this summary.

(same)	DX 77	Dr. Gaziano, B[18]	Positive for pneumoconiosis, profusion 1/0,[19] type q/t opacities[20]
(same)	DX 79	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/1, type p/t opacities
Jul 6, 1999 (portable)	DX 64	Dr. DePonte	Chronic obstructive pulmonary disease, no active infiltrates
(same)	DX 66	Dr. Wheeler, BCR, B	Healed TB, negative for pneumoconiosis
(same)	DX 66	Dr. Scott, BCR, B	Possible calcified granulosa, negative for pneumoconiosis
(same)	DX 67	Dr. Kim, BCR, B	Calcified granulosa, negative for pneumoconiosis
(same)	EX 3	Dr. Wilt, BCR., B	(The portable study is unacceptable for pneumoconiosis study)
Oct 27, 1999	DX 60	Dr. Wheeler, BCR, B	Minimal emphysema, healed TB, negative for pneumoconiosis
(same)	DX 60	Dr. Scott, BCR, B	Emphysema, healed infection, negative for pneumoconiosis, emphysema
(same)	DX 62	Dr. McSharry	Unidentified fibrosis, not pneumoconiosis

[18]B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[19]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1.

[20]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

(same)	DX 63	Dr. Wilt, BCR, B	Fibrotic markings consistent with a "past inflammatory process," negative for pneumoconiosis
(same)	EX 4, pages 15 & 16	Dr. Hippensteel, B	Positive for pneumoconiosis, profusion 1/0, type s/q opacities
Mar 3, 2000	DX 79	Dr. Saha	Chronic pulmonary interstitial disease
(same)	DX 65	Dr. Meyer, BCR, B	Possible focal opacity, negative for pneumoconiosis, possible focal opacity
(same)	DX 78	Dr. Gaziano, B	Negative for pneumoconiosis
Aug 15, 2001	EX 3	Dr. Hippensteel, B	Positive for pneumoconiosis, profusion 1/2, type p/q opacities
(same)	EX 6	Dr. Wheeler, BCR, B	Emphysema, negative for pneumoconiosis
(same)	EX 6	Dr. Scott, BCR, B	Bulbous emphysema, negative for pneumoconiosis

Dr. Joseph F. Smiddy
(DX 57, DX 69, and DX 79)

On February 18, 1999, Dr. Smiddy, board certified in internal medicine, examined Mr. Horner's pulmonary condition. At that time, Mr. Horner complained about chronic shortness of breath. He had a coal mining employment history of 27 years and remained a long term cigarette smoker. His medical history included a heart attack in 1981 with long-standing diagnoses of emphysema and pneumoconiosis. The physical examination revealed a prolonged expiratory phase. A month later, after receiving pulmonary, respiratory, and chest x-ray results, Dr. Smiddy concluded Mr. Horner had severe coal workers' pneumoconiosis with underlying chronic bronchitis and COPD (chronic obstructive pulmonary disease). Dr. Smiddy believed the extent of pneumoconiosis was sufficient "to produce 100% total and permanent disability."

On March 2, 2000, Dr. Smiddy again examined Mr. Horner concerning his breathing medications. Mr. Horner still had a prolonged expiratory phase. Dr. Smiddy indicated Mr. Horner had coal workers' pneumoconiosis, COPD and nicotine addiction.

Dr. Roger J. McSharry
(DX 62 and EX 5)

On October 27, 1999, Dr. McSharry, board certified in pulmonary and internal medicine, conducted a pulmonary examination of Mr. Horner. Mr. Horner had 26 years of coal mine employment and had used cigarettes up to the day of the exam for 33 years from one to two packs a day. His medical history included myocardial inactions in 1981 and 1999. During the physical examination, the lungs were clear. The chest x-ray was negative, the pulmonary function tests were

near normal and the blood gas study revealed mild hypoxemia and continued cigarette use. Based on his examination, Dr. McSharry diagnosed myocardial inactions and chronic bronchitis. Mr. Horner did not have pneumoconiosis. Finally, despite Mr. Horner's shortness of breath complaints, Dr. McSharry stated there was no objective medical evidence of a respiratory impairment.

In a September 2001, Dr. McSharry provided further elaboration of his diagnosis. He recalled that Mr. Horner complained about chronic shortness of breath even walking on level ground and an inability to climb stairs without stopping. Dr. McSharry was aware of the strenuous nature of Mr. Horner's last job as a coal miner and the requirement to lift and carry up to 50 pounds. Since the physical examination of the lungs was unremarkable, the pulmonary function test indicated a trivial amount of an obstruction, and the blood gas was "essentially normal," Dr. McSharry concluded Mr. Horner has the respiratory capacity to return to his last coal mine employment. Based on all the test results and chest x-ray, Dr. McSharry again opined that Mr. Horner did not have coal workers' pneumoconiosis.

Dr. W.K.C. Morgan
(EX 1)

In August 2001, after conducting a medical record review, which included the recently developed medical evidence, Dr. Morgan opined that Mr. Horner did not have coal workers' pneumoconiosis considering his limited exposure to heavy coal dust and the negative radiographic evidence. Additionally, in light of the pulmonary function test results, and though the blood gas studies were on the low side, Mr. Horner still suffered only a mild airways obstruction which would not preclude his return to his last job as a coal miner. Dr. Morgan diagnosed Mr. Horner's "mild" pulmonary impairment as emphysema and bronchitis which are caused by his cigarette smoking. From a respiratory perspective Mr. Horner is not totally disabled. At the same time, his recent heart attack probably makes coal mining unsuitable work for him.

Dr. Samuel V. Spagnolo
(EX 1)

In September 2001, Dr. Spagnolo, board certified in pulmonary disease and internal medicine, also conducted a review of Mr. Horner's medical records. After noting Mr. Horner's 26 years of coal mine employment, his long term cigarette smoking habit, and considering the diverse medical tests and reports, Dr. Spagnolo concluded there were no consistent physical findings or objective medical evidence of "any chronic disease of the lung arising from coal mine employment." He highlighted the normal pulmonary function test, normal arterial blood gas studies and Dr. McSharry's normal pulmonary examination findings. Thus, Mr. Horner has the respiratory capacity to return to his last coal mining job. Giving greater credence to the board certified radiologists who were recognized experts, Dr. Spagnolo opined that the radiographic evidence also failed to establish the presence of pneumoconiosis.

Dr. S.K. Paranthaman

(EX 2)

In his August 2001 review of Mr. Horner's medical record, which included Dr. Smiddy's observations from 1999 and 2000, Dr. Paranthaman, board certified in pulmonary disease and internal medicine, noted that Mr. Horner had 26 years of coal mine employment and an extensive cigarette smoking history. Based on chest x-ray interpretations, Dr. Paranthaman believed Mr. Horner did have coal worker's pneumoconiosis. However, the pulmonary function tests showed only a mild airway obstruction and the blood gas studies demonstrated mild hypoxemia. As a result, Mr. Horner had only a mild respiratory impairment due in part to coal dust exposure and bronchitis due to cigarette smoking. From a respiratory perspective, Mr. Horner was not totally disabled from coal mine employment. If he were disabled, such an impairment is due to his cardiac problems and chronic bronchitis from cigarette smoking. Coal workers' pneumoconiosis would have aggravated such a condition "to an unknown extent."

Dr. James R. Castle
(EX 2)

In September 2001, Dr. Castle, board certified in internal medicine and pulmonary disease, conducted a medical record review. Noting that he had previously examined Mr. Horner during the prior claim, Dr. Castle considered Mr. Horner's coal mine employment and cigarette smoking histories. Then, he stated that both the preponderance of the chest x-ray interpretation, which are negative, and the absence of consistent physical findings support his conclusion that Mr. Horner does not have pneumoconiosis. Further, while the earlier pulmonary tests demonstrated a mild obstruction, the most test by Dr. McSharry was "essentially normal." The blood gas studies were normal considering Mr. Horner's age. Consequently, Mr. Horner does not have a pulmonary disability and has the respiratory capacity to perform "any, and all" coal mine employment duties. At the same time, Mr. Horner's cardiac condition, which is unrelated to his coal mine employment, may be totally disabling.

Dr. Kirk E. Hippensteel
(EX 3 and EX 4)

On August 15, 2001 Dr. Hippensteel, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation. Mr. Horner reported that he had undergone a coronary artery stent operation in 1999 and continued to smoke cigarettes. On physical examination, Dr. Hippensteel heard minimal wheeze and good air movement. Based on own interpretation of a chest x-ray, Dr. Hippensteel could not rule out the presence of simple pneumoconiosis. At the same time, the pulmonary function test indicated a minimal obstruction and the blood gas study was normal for Mr. Horner's age. So, though Mr. Horner may have radiographic signs of pneumoconiosis, he has no significant pulmonary impairment from his coal dust exposure. According to Dr. Hippensteel, Mr. Horner "does not have ventilatory or gas exchange impairment enough of a degree from any cause to keep him from going back to his job in the miners." Mr. Horner does have chronic bronchitis due to his continued smoking, a significant heart problem, and hypertension. In combination, these three

health issues may combine to render Mr. Horner totally disabled. Dr. Hippensteel also conducted a medical record review and observed a conflict in the chest x-ray evidence concerning the presence of coal worker's pneumoconiosis. However, the remaining medical evidence reconfirmed his assessment that Mr. Horner does not have a permanent impairment of his pulmonary functions or gas exchange capabilities.

In a subsequent September 2001 deposition, Dr. Hippensteel provided more detail on his assessment of Mr. Horner's pulmonary condition. Prior to his testimony, he had reviewed the recent reports of Dr. Morgan, Dr. Paranthaman, Dr. Spagnolo, and Dr. Castle. Plus, he reviewed the October 27, 1999 chest x-ray. At his examination, Mr. Horner described a chronic and long term breathing problems, including shortness of breath upon exertion. However, because the pulmonary function test produced results which would not be associated with breathing discomfort, Dr. Hippensteel opined Mr. Horner's breathing problems were related to this coronary artery heart disease. Regardless, Mr. Horner does have the *pulmonary* capacity to do any job in the mines involving heavy labor.

Discussion

In light of the conflicting medical opinions, I must first assess the relative probative value of the medical evaluations and then determine whether Mr. Horner is able carry his burden of proving total respiratory disability through the preponderance of the more probative medical opinion. Since most of the physicians in this case are similarly qualified, the two factors I will consider in evaluating relative probative weight are: a) documentation and b) reasoning.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation, such as chest x-rays, pulmonary function tests, arterial blood gas studies, and physical examinations. *Hoffman v. B & G Construction Company*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor of reasoning involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight . *Fields v. Island Creek Coal Company*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Company*, 11 B.L.R. 1-91 (1988).

With these considerations in mind, I find the medical opinion of Dr. Smiddy to have diminished probative value due to both documentation and reasoning deficits. In terms of documentation, Dr. Smiddy did examine Mr. Horner at least twice, but he apparently only considered the February 1999 pulmonary function test and blood gas study. The other physicians to evaluate Mr.

Horner's pulmonary condition reviewed several other pulmonary and arterial blood gas tests.

More importantly, I find Dr. Smiddy' opinion that Mr. Horner is 100% totally disabled by pneumoconiosis not to be well reasoned. Although he mentioned the pulmonary and respiratory tests of February 1999, Dr. Smiddy apparently reached his conclusion based on a chest x-ray finding of "severe" pneumoconiosis. However, he not explain how he integrated the February 1999 breathing tests with his severe pneumoconiosis diagnosis and finding of total disability and failed, due to the previously mentioned documentation shortfall, to address the other objective medical tests in the record (for example, the subsequent October 1999 breathing studies) that showed near normal or normal respiratory capacity.

Further, Dr. Smiddy's apparent reliance on a chest x-ray interpretation is an insufficiently reasoned basis for establishing total respiratory disability. Other than the presumption generated by the presence of complicated pneumoconiosis,[21] the radiographic extent of pneumoconiosis, standing alone, does not establish total disability. Absent that presumption, Dr. Smiddy must point to other objective tests that show Mr. Horner is no longer able to bear the heavy physical demands associated with his work as a coal mine utility man. Dr. Smiddy's failure to make such connections is particularly significant considering the vast array of pulmonary function and blood gas test results which show Mr. Horner has no more than a slight pulmonary impairment at this time despite the presence of any pneumoconiosis.

In contrast, the other opinions from the remaining host of pulmonary experts are both well documented and reasoned. Dr. McSharry, Dr. Morgan, Dr. Spagnolo, Dr. Paranthaman, Dr. Castle, and Dr. Hippensteel, while disagreeing in part on whether Mr. Horner had pneumoconiosis, provided well reasoned medical opinions that rested on an extensive series of objective medical tests, in the form of pulmonary function tests, arterial blood gas studies, and physical examination findings, which established that Mr. Horner's respiratory capacity was at least near normal. Additionally, Dr. McSharry, Dr. Paranthaman, and Dr. Hippensteel compared that medically-demonstrated near-normal pulmonary capacity to the heavy physical requirements of Mr. Horner's last coal mine job to reasonably conclude he was still capable of such work from a respiratory perspective.

Even if I found Dr. Smiddy's opinion supporting Mr. Horner's claim of total respiratory disability to be well documented and reasoned, Mr. Horner still would not prevail because Dr. Smiddy's opinion of total disability stands alone. His lone opinion that Mr. Horner has a total respiratory impairment is clearly overwhelmed by the consensus of the other physicians that Mr. Horner does not have such an impairment. In this case, the well documented and reasoned medical opinions of Dr. McSharry, Dr. Morgan, Dr. Spagnolo, Dr. Paranthaman, Dr. Castle, and Dr. Hippensteel represent the preponderance of the medical opinion. Based on that preponderance of medical opinion, I find Mr. Horner can not prove a totally disabling pulmonary or respiratory impairment by medical opinion.

B. Mistake of Fact - Total Disability

[21] 20 C.F.R. § 718.304.

Because neither the pulmonary function tests, arterial blood gas studies, nor the preponderance of the medical opinion establishes the Mr. Horner has developed a total pulmonary impairment since November 1997, he is unable to prove a change in condition to support his modification request. However, modification may still be appropriate if the record shows a mistake in the determination of fact occurred during the prior adjudication of his claim. In determining whether a mistake in a determination of fact occurred , an administrative law judge must review all of the evidence in the record, both old and new. *Kinjery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994).

As summarized by Judge Levin in his November 1997 denial of benefits, the evidence in the record before him did not enable a finding of total respiratory disability. None of the pulmonary function tests, arterial blood gas studies or physicians' opinions supported a finding of a total pulmonary impairment. Additionally, no doctor found evidence of cor pulmonale. As I have just discussed in my change in condition evaluation, the objective medical tests conducted since November 1997 still fail to show total respiratory impairment and no physician has diagnosed cor pulmonale. On the other hand, at least one physician, Dr. Smiddy, since November 1997 has concluded that Mr. Horner is totally disabled. However, as also determined above, his opinion that Mr. Horner has a total pulmonary impairment is overwhelming outweighed by the consensus of the other pulmonology experts who concluded Mr. Horner retains the respiratory capacity to return to his last job as a coal miner. Consequently, the preponderance of the new physician opinions still fails to establish total disability. Ultimately, all of the evidence in record by November 1997 and almost all of the new evidence developed since then demonstrates that Mr. Horner is not totally disabled from a respiratory perspective. In other words, in light of the medical record up to the date of Judge Levin's November 1997 coupled with the medical evidence developed since then, the prior determination that Mr. Horner failed to establish total disability under the Act was correct. Accordingly, I conclude no mistake of fact occurred in Judge Levin's adjudication, and denial, of Mr. Horner's claim.

CONCLUSIONS

Despite the extensive medical tests, examinations, and reviews that have been accomplish to evaluate Mr. Horner's pulmonary condition since the denial of his claim by Judge Levin in November 1997, Mr. Horner is unable to show that his respiratory condition has changed to the extent that he is now totally disabled by a pulmonary condition and unable to return to his work as a coal mine utility man. All of the pulmonary function tests and arterial blood gas studies failed to support such a disability. The preponderance of the probative medical opinion also does not support a total respiratory disability finding. Similarly, review of the entire record discloses no mistake in the adjudication of an essential fact. Consequently, Mr. Horner's request for modification, based either on a change in conditions or a mistake of fact, must be denied.

In turn, having failed to establish that modification of Judge Levin's denial of his claim for benefits under the Act, as affirmed by the Benefits Review Board, is appropriate, Mr. Horner is not

able to alter the finality of Judge Levin's decision. And, since Judge Levin's decision and order has remained final, Mr. Horner is also unable to now withdraw the underlying claim. Accordingly, Mr. Horner's request to withdraw his claim for benefits under the Act must be denied.

ORDER

The modification request of Mr. CURTIS M. HORNER, dated September 21, 1999, is **DENIED**.

The withdrawal of claim request of Mr. CURTIS M. HORNER, presented June 23, 2001, is **DENIED**.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: May 30, 2002
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.